



To: Dr. Rick Hong
Group Chair, Delaware Public Health and Medical Ethics Advisory Group







From: Todd W. Heintzelman, Senior Associate Delta Development Group, Inc

Date: September 27, 2018

Reference: Delaware Public Health and Medical Ethics Advisory Group Meeting

The Delaware Public Health and Medical Ethics Advisory Group held a meeting on September 25th, 2018 at 1:00 p.m. at the Emergency Medical Services and Preparedness Section (EMSPS) offices in Smyrna, DE. The following were in attendance either in person or via conference call.

NAME	ORGANIZATION	E-MAIL
Lisandra Clarke	Division of Public Health	lisandra.clarke@state.de.us
Betty Decker	Division of Public Health	betty.decker@state.de.us
Shawn Foster	Division of Public Health	shawn.foster@state.de.us
Keith Goheen	Beebe Healthcare	kgoheen@beebehealthcare.org
John Goodill	Delaware Quality of Life Coalition	jgoodill@christianacare.org
Diane Hainsworth	Division of Public Health	diane.hainsworth@state.de.us
Kristin Harvey	Delaware Developmental Disabilities Council	kristin.harvey@state.de.us
Rick Hong	Division of Public Health	rick.hong@state.de.us
Kristen Hyland	Wilmington VA Medical Center	kristen.hyland@va.gov
Linda Popels	Division of Public Health	linda.popels@state.de.us

Malikah Taylor	Division of Public Health	 malikah.taylor@state.de.us
Jamie Towns	Division of Services for Aging and Adults with Physical Disabilities	 franklin.towns@state.de.us
Jane Walmsley	Westside Family Healthcare	 jane.walmsley@westsidehealth.org
Erin Goldner	Hope Street Delaware	 eringoldner@hopestreetde.com
Robert Ross	Delta Development Group	 rwross@deltaone.com
Todd Heintzelman	Delta Development Group	 theintzelman@deltaone.com

II. Welcome and Introductions

- A. The meeting opened with welcome and introductions.

III. Ethics Advisory Group Standard Operating Guidelines (SOG) Review

- A. The Group reviewed the draft SOG and recommended changes and edits. Below are the significant updates:
1. Create co-chairs instead of a Chair and Vice-Chair with one of the co-chairs a Delaware Division of Public Health employee. Update the rules for voting based on co-chairs.
 2. Provide the Delaware Division of Public Health Director with the vote count for each opinion.
 3. Include a confidentiality agreement in the SOG.
 4. Better specify the roles of subject matter experts that advise the group.

IV. Overview of Delaware Opioid Response

- A. Diane Hainsworth provided an overview of the current status of Delaware's opioid situation and the development of Delaware's opioid response program. (See Attachment 1)
- B. Delaware was just awarded a \$6 million federal grant to fight the opioid crisis. Part of this money includes a Narcan grant which is enough money to provide every first responder in Delaware with Narcan.
- C. The healthcare system as a whole must develop a comprehensive plan for opioids. Historically, the different divisions of the Department of Health and Social Services and functions provided by first responders would develop programs for their individual requirements but would not work together to synchronize their programs into a comprehensive plan.
-

- D. The opioid crisis requires enhanced surveillance and situational awareness due to how fast it is evolving. Delaware can't rely on traditional medical and crime reporting data since these can be up to a year old. Delaware publishes the "Delaware Drug Monitoring Initiative" quarterly so the information isn't necessarily timely.
- E. Delaware National Guard Civil Support Team can test samples of drugs to identify the specific chemicals in the drug if there is a sudden outbreak of overdoses.
- F. 60% of overdoses happen in a residence. 80% of overdose deaths in Delaware were caused by opioids. The majority of overdose deaths happen when the person takes the drug and they are alone.
- G. 50% of people who are revived with Narcan do not seek immediate medical treatment in the emergency department.
- H. There are two different type of people who present themselves to emergency departments at hospitals; a person who has overdosed or a person who had received Narcan earlier but has relapsed because of Narcan's half-life.
- I. Delaware has updated the law to allow all public first responders to carry Narcan including police, firefighters, and campus police.
- J. John Goodill, who is also a member of the Addiction Action Committee, said there is an effort to decrease the prescribing opioids by physicians. He said there is a place and need to prescribe opioids for certain medical issues but the medical community needs to find the right balance. He also stated that the medical community does not treat addiction very well and it is hard for those with a drug addiction or substance use disorders to get treatment.
- K. Diane Hainsworth said that Delaware is developing "What is Addiction" and "Empathy" training.
- L. Delaware passed the System of Care bill which brings together people from all areas to talk about how to treat addiction.
- M. Kristin Harvey commented that the people who help develop the system of care should put themselves in the same shoes of people who have substance use disorders. Many of them are in pain, have a rift with their family or friends, have lots of emotional issues, and little to no money. Based on numerous factors, it is unlikely that they would want to go to a hospital if they suffer an overdose.
- N. The total cost for acute overdose treatment in the United States is \$500 billion a year.

V. Discussion of Ethical Questions:

- A. If under the influence, can a patient determine care?
 - 1. The Group discussed this question and felt that if the patient is not confused and is "awake, alert, and oriented" then they can refuse service.
 - B. If given Narcan, and they are able to breathe and are not confused, can a patient determine care?
 - 1. The Group discussed this question and felt that if the patient is not confused and is "awake, alert, and oriented" then they can refuse service.
-

- C. Rick Hong stated that emergency departments in hospitals are not equipped to provide substance use disorder patients the help they need. The emergency rooms are equipped to provide acute medical care. Emergency departments are able to prescribe drugs to help treat the symptoms of withdrawal but they are unable to follow up on the patient to make sure the patient is getting drug addiction treatment.
 - D. Diane Hainsworth discussed Delaware's plans on creating "stabilization centers" where EMS can take overdose patients to seek medical and drug treatment instead of to a hospital emergency department. There are legal, regulatory, and financial issues that need solved before the stabilization centers are created.
 - E. Keith Goheen asked the question about "capacity versus competency". Overdose patients that are treated with Narcan might have the capacity to refuse service but are they competent, based on their addiction, to refuse treatment? If they are not competent, then who can provide surrogate medical decisions for them?
 - F. The Group further discussed that addiction is not a new problem. For instance, in the 1980's there was an addiction epidemic with cocaine and crack epidemic while the 1990's and early 2000's witnessed a methamphetamine epidemic. However, the current opioid crisis is larger in scope and requires more resources than previous drug addiction epidemics.
 - G. Diane Hainsworth discussed that EMS call volume is up by 13% due to the number of overdose calls. There have been recent incidents in Delaware where there are two medical emergency calls at the same time, one for a heart attack and one for an overdose, but there is only one ambulance available. The police in the jurisdictions in this situation carried Narcan so the EMS was dispatched to the heart attack patient while the police were dispatched to the overdose patient.
 - H. Diane Hainsworth also discussed Delaware's Narcan guidance for first responders. The guidance is to provide 1mg to an overdose patient at first and then only provide the 2mg if they need it to regain respiratory capability. This way an overdose patient is less likely to be "awake, alert, and oriented" and to refuse treatment. However, this only pushes the overall problem of getting the person into drug treatment from the first responders to the emergency department. There is a linkage break in the current treatment process from the first responders to the drug addiction centers.
 - I. The Group discussed some issues about sending drug overdose patients to hospital emergency departments. One of the problems is that the overdose patient takes a bed away from person with another type of medical emergency. A second issue is that the emergency department is only designed to physically wake the person from an overdose, they are unable to hold the person in the emergency department while they wait for in-house addiction treatment. Addiction treatment centers and hospitals do not interact well together and there are many administrative barriers to get people into addiction treatment resulting in wait times of 48 hours or more. The emergency department usually has to release the patient before they are admitted for treatment. The patient, since they have substance use disorder, leave the hospital and get high and, in most cases, do not go to their in-patient treatment. Diane Hainsworth said that the stabilization centers are designed to eliminate these problems since they are a safe place where EMS can take overdose patients to get medical help and stay until they are admitted into drug rehab treatment center.
-

- J. Rick Hong and Kristen Hyland both related an experience where they were able to keep a homeless substance use disorder patient in the emergency department until they were admitted for drug rehabilitation. This was extremely difficult to accomplish and is not an optimal solution to getting substance use disorder treatment.
- K. John Goodill posed the question if you can legally and medically classify substance use disorder patients the same as suicidal patients. Hospitals can hold suicidal people because they are going to cause “harm to themselves”. Substance use disorder patients are going to harm themselves so are we able to legally link the two?
- L. Kristin Harvey related the story about how her friend’s son died of a drug overdose with a group of friends. Her son’s friends were scared about being arrested if they called 911 so they did not seek medical help for her son and he died. They rolled his body up in a rug and dumped it in a strip mall parking lot.
- M. The Group then discussed the root cause of addiction. There was a consensus that mental health is a major cause of addiction and that the mental health system is not very robust. The current medical system pays huge amount of money for people who treat physical medical problems but does not pay very much money to people who treat mental health problems.
- N. Kristen Hyland said that the VA provides free Narcan to all veterans and believes that this has saved 13 lives. The VA found that most of the veterans are getting the Narcan not for themselves but for their family or friends. She relayed that it is very hard to get people into outpatient treatment.
- O. Kristin Harvey asked if Delaware has interviewed recovering substance use disorder patients to determine what they really needed to get help. Diane Hainsworth said that Delaware has looked at other programs across the country that have been successful and also has held focus group meetings with a variety of groups, including recovering substance use disorder patients and their families, to help develop Delaware’s system of care.

VI. Closing.

- A. Rick Hong recapped the meeting stating that it helped educate the group on the current opioid crisis and Delaware’s system of care.
- B. Rick Hong said that the group will vote for approval of the updated SOG by an on-line survey or by other electronic means.
- C. Rick Hong stated that there are many legal and regulatory barriers to the system of care and the stabilization centers. The group might provide help to get support for the system of care by highlighting the ethical issues of the opioid crisis.
- D. The next group meeting is planned for late January or early February.

VII. Adjournment.

There being no further comments, the meeting was adjourned at 3:00 p.m.

Opioid Crisis in Delaware

Diane Hainsworth
EMSPS



Emergency Medical Services and Preparedness Section

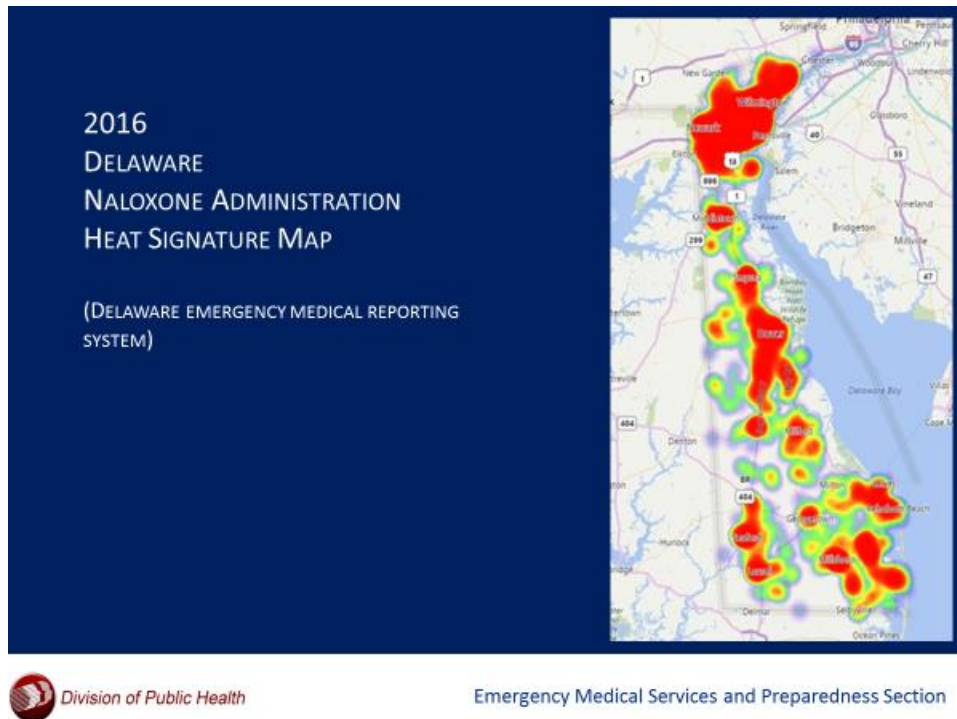
What do you know about the Opioid Crisis in Delaware

- Does it affect you?

- Who?
- What?
- When?
- Where?
- How?



Emergency Medical Services and Preparedness Section



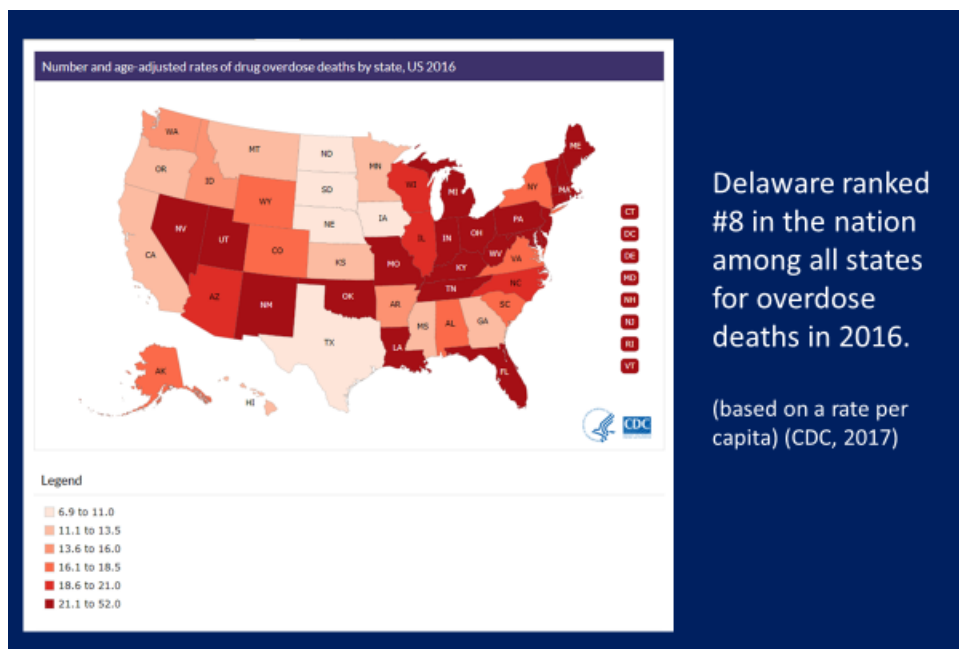
Delaware Opioid Statistics

- During calendar year 2017, the Division of Forensic Sciences reports that 345 people died as a result of an overdose.
- Emergency Department visits for suspected overdose related incidents for 2017 was 2,095. (ESSENCE, 2018)
- Emergency medical services records indicated that 1,905 patients received naloxone from EMS during 2017.
- As of 9/20/2018 there were 208 suspected overdose deaths reported for 2018 (DHSS website)

Attachment 1 (Opioid Crisis in Delaware)

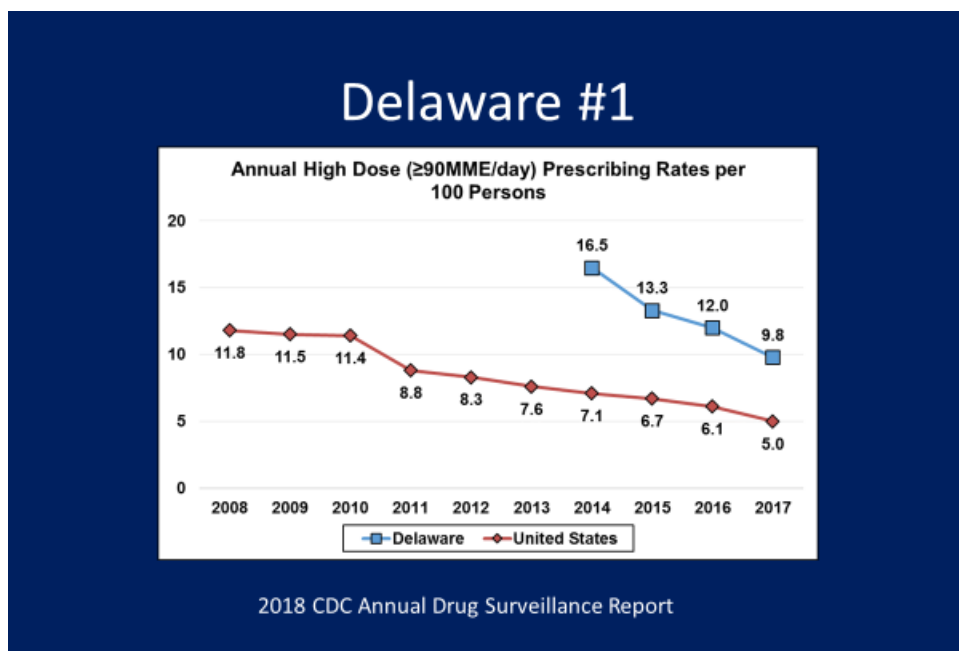
Delaware Public Health and Medical Ethics Advisory Group Meeting

September 25th, 2018



Division of Public Health

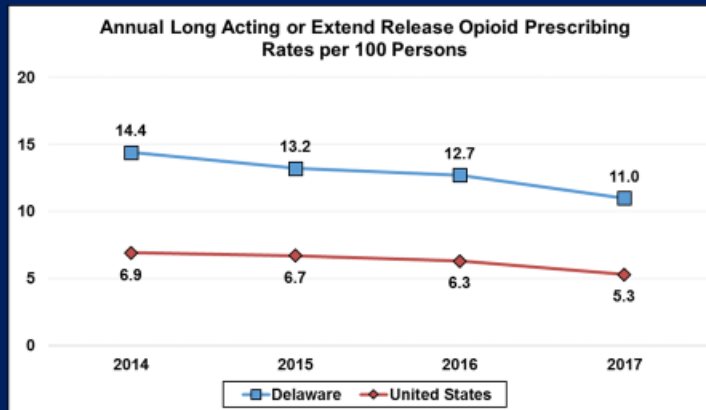
Emergency Medical Services and Preparedness Section



Division of Public Health

Emergency Medical Services and Preparedness Section

Delaware #1



2018 CDC Annual Drug Surveillance Report



Division of Public Health

Emergency Medical Services and Preparedness Section

Treatment of the Acute Overdose

- The issue with Opioids is one of respiratory depression.
- Currently EMS and other 1st Responders are using Naloxone to reverse the effects of an Opioid overdose.
- During 2nd qtr 2018 there was a 28% increase in Naloxone administrations throughout the state.
 - Kent County increased 44%
 - Sixty eight percent overdosed at home
- Costs



Division of Public Health

Emergency Medical Services and Preparedness Section

Now that we have your attention....



Emergency Medical Services and Preparedness Section